MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

3422 Item 12 Film 6-9-58 et

Reg. Dist. No. 03407

1. PLACE OF DEATH
a. COUNTY: Howard — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkridge
c. LENGTH OF STAY IN 1b: 75 Yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 6410 Old Washington Blvd.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Howard
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkridge
d. STREET ADDRESS: 6410 Old Washington Blvd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Augusta Middle A. Last Barklage

4. DATE OF DEATH: Month March Day 16 Year 1958

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Sept. 26, 1875
9. AGE (In years last birthday): 82 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House work
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Germany
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Margaret Schatz — Address: 6410 Old Washington Blvd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Cerebral Hemorrhage	5 hrs
DUE TO (b)	Arteriosclerosis	6 mos
DUE TO (c)	General Arteriosclerosis	5 yrs

422.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Duodenal ulcer

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June, 1957, to March 16, 1958 that I last saw the deceased alive on March 16, 1958, and that death occurred at 12:45 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: H B Brumbaugh M.D. — ADDRESS (Street, city or town, state): 7609 Main St Elkridge — DATE SIGNED: 3/17/58

PHYSICIAN'S NAME (Type): H B Brumbaugh — 7609 Main St Elkridge

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/19/58
22c. NAME OF CEMETERY OR CREMATORY: St. Augustine
22d. LOCATION (City, town, or county) (State): Elkridge, Howard, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Ambrose, Inc. — ADDRESS: 1328 Sulphur Spring Rd.
24a. REC'D BY REGISTRAR DATE: MAR 19 '58
24b. REGISTRAR'S SIGNATURE: W. Pearce

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3423

CERTIFICATE OF DEATH

Reg. Dist. No. 03408

1. PLACE OF DEATH
a. COUNTY: Howard — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Mt Airy
c. LENGTH OF STAY IN 1b: 2 mos
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Route 3 - Mt Airy

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: District of Columbia
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 3106 M St. NW
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Anna Middle Belle Last Becraft

4. DATE OF DEATH: Month March Day 10 Year 1958

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 4-22-1882

9. AGE (In years last birthday): 75 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Edward S. Duvall

14. MOTHER'S MAIDEN NAME: Catherine A. Young

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mrs. Frank Renn, Address: Mt Airy, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 5 years
420.0
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) ___
DUE TO
(c) ___

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from January, 1958, to March, 1958, that I last saw the deceased alive on March 9, 1958, and that death occurred at 10:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: W.B. Culwell M.D. ADDRESS (Street, city or town, state): Mt. Airy DATE SIGNED: 3/10/58

PHYSICIAN'S NAME (Type): W.B. Culwell Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3-13-1958

22c. NAME OF CEMETERY OR CREMATORY: Pine Grove

22d. LOCATION (City, town, or county) (State): Mt Airy, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: C.M. Waltz ADDRESS: Winfield, Md.

24a. REC'D BY REGISTRAR DATE: MAR 13 '58

24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3424 CERTIFICATE OF DEATH

Reg. Dist. No. 03409

1. PLACE OF DEATH
a. COUNTY: Howard — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ellicott City
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Shaffers Convalescent Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Howard
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): × Ellicott City
d. STREET ADDRESS: 503 Oakland Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First ELIZABETH Middle WEST WHITE Last COUNCELL

4. DATE OF DEATH: Month Mar. Day 24, Year 19 58

5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: June 23, 1871
9. AGE (In years last birthday): 86 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: at home
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John Wesley White
14. MOTHER'S MAIDEN NAME: Henrietta Sophia Tannehill

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): —
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Address Ellicott City, Md.
Mr. Marbury Councell - 503 Oakland Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CARDIAC ARREST — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO
(b): CARDIAC DECOMPENSATION — 2 MOS.
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 9047 4344

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): FRACTURED LEFT HIP

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): SIMPLE FALL
20c. TIME OF INJURY Hour o. m. / p. m. 2 p. m. Month, Day, Year 1-17 1958
20d. INJURY OCCURRED While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): SHAFFER'S NURSING HOME
20f. (City or town) (County) (State): ELLICOTT CITY, HOW.

21. I certify that I attended the deceased from ____, 1956, to 3-21, 1958, that I last saw the deceased alive on 3-21, 1958, and that death occurred at 1 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: P V Thorpe M.D.
ADDRESS (Street, city or town, state): ELLICOTT CITY
DATE SIGNED
PHYSICIAN'S NAME (Type): PETER V. THORPE, MD M.D. 3-25-58

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/26/58
22c. NAME OF CEMETERY OR CREMATORY: Druid Ridge Cem.
22d. LOCATION (City, town, or county) (State): Pikesville, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Wm. J. Tichner & Son - Baltimore, Md
ADDRESS:
24a. REC'D BY REGISTRAR DATE MAR 27 '58
24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3425 CERTIFICATE OF DEATH

03410
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Howard — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ellicott City
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Howard
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ellicott City
d. STREET ADDRESS: Pine Orchard
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Joshua — Middle: H. — Last: Cross

4. DATE OF DEATH: Month: March — Day: 30 — Year: 1958

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Dec. 27, 1874
9. AGE (In years last birthday): 83 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farm Owner
10b. KIND OF BUSINESS OR INDUSTRY: Retired
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Thomas S. Cross
14. MOTHER'S MAIDEN NAME: Emma Stansfield

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Miss. Charity Cross — Address: Ellicott City, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 2 days
422.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): —
DUE TO
(c): Arteriosclerotic Cardio-Vascular Disease. — 2 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): None

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct 20, 1954, to May 30, 1958, that I last saw the deceased alive on May 29, 1958, and that death occurred at 1 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: William F. Gassway, M.D. — ADDRESS (Street, city or town, state): Ellicott City, Md. — DATE SIGNED: 3/30/58

PHYSICIAN'S NAME (Type): William F. Gassway — Ellicott City, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 4/2/58
22c. NAME OF CEMETERY OR CREMATORY: Mt. View
22d. LOCATION (City, town, or county) (State): Alpha Md.

23. FUNERAL DIRECTOR'S SIGNATURE: F.C. Higinbothom — ADDRESS: Ellicott City, Md.

24a. REC'D BY REGISTRAR DATE: APR 2 '58
24b. REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

3426

Reg. Dist. No. 03411

1. PLACE OF DEATH
a. COUNTY Howard — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Scaggsville
c. LENGTH OF STAY IN 1b 20 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Gorman Road

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland
b. COUNTY Howard
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Scaggsville
d. STREET ADDRESS Gorman Road
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print) First: Chester Middle: Barfield Last: GILBERT

4. DATE OF DEATH Month: March Day: 22 Year: 1958

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: July 26 1880

9. AGE (In years last birthday) 77 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): mining engineer

10b. KIND OF BUSINESS OR INDUSTRY: mining industry

11. BIRTHPLACE (State or foreign country): Patchogue Long Island N.Y.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: unknown

14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Address: Mrs Janet Gilbert Scaggsville Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 day
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying couse last.
(b) Arteriosclerotic C-V-Dis — 20 Yrs
DUE TO
(c) Gen Arterios Dis — 20 Yrs

H 20.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1/11/55 19__, to 3/22/55, that I last saw the deceased alive on 3/22/55 19__, and that death occurred at __M, from the causes and on the date stated above.

ACTUAL SIGNATURE J. M. Warren M.D.
ADDRESS (Street, city or town, state) Laurel
DATE SIGNED 3-22-55

PHYSICIAN'S NAME (Type) J. M. WARREN

22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation

22b. DATE THEREOF March 24, 1958

22c. NAME OF CEMETERY OR CREMATORY Dust Lincoln Cr.

22d. LOCATION (City, town, or county) (State) Colmar Manor Md

23. FUNERAL DIRECTOR'S SIGNATURE De Witt Donaldson ADDRESS Laurel Md.

24a. REC'D BY REGISTRAR DATE MAR 26 '58

24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3427 CERTIFICATE OF DEATH

Reg. Dist. No. 03412

1. PLACE OF DEATH
a. COUNTY: Howard — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ellicott City
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: St. Johns Lane

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Howard
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ellicott City
d. STREET ADDRESS: St. Johns Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First FRANCES Middle LOUISE Last HARDMAN

4. DATE OF DEATH: Month March Day 22 Year 19 58

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: May 18, 189[illegible]

9. AGE (In years last birthday): 67 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At Home

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Catonsville, Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: James Henry Floyd

14. MOTHER'S MAIDEN NAME: Wilhelmina Umbaugh

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Carl Myers, Ellicott City, Md
Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a). (b). and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral vascular accident — INTERVAL BETWEEN ONSET AND DEATH: 5 min.
331 X
DUE TO
(b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour a. m. / p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1-20, 19 58, to 3-22, 19 58, that I last saw the deceased alive on 3-17, 19 58, and that death occurred at 8:05 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Thomas F. Herbert M.D.
ADDRESS (Street, city or town, state): 46 Church Road
DATE SIGNED: 3/22/58

PHYSICIAN'S NAME (Type): Thomas F. Herbert, M.D. Ellicott City, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3-25-58
22c. NAME OF CEMETERY OR CREMATORY: St. Johns
22d. LOCATION (City, town, or county) (State): Ellicott City, Md

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: F. C. Higinbothom, Ellicott City, Md.

24a. REC'D BY REGISTRAR DATE: MAR 26 '58
24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3428

CERTIFICATE OF DEATH

Reg. Dist. No. 03413

1. PLACE OF DEATH
a. COUNTY: Howard — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Poplar Springs
c. LENGTH OF STAY IN 1b: 2 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: R.F.D.# 3, Mt. Airy

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Howard
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Poplar Springs
d. STREET ADDRESS: R.F.D. # 3 Mt. Airy
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First John Middle Howard Last Hardy

4. DATE OF DEATH: Month March Day 1 Year 1958

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: June 17, 1880
9. AGE (In years last birthday): 77 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Own Farm
11. BIRTHPLACE (State or foreign country): Howard Co., Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles H. Hardy
14. MOTHER'S MAIDEN NAME: Miranda Young

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT Address: Mrs Sadie M. Hardy, Mt. Airy, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteria Sclerotic Heart Disease
DUE TO (b): Generalized Arterio Sclerosis
DUE TO (c):
420.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: Yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan. 1945, to Mar 1, 1958, that I last saw the deceased alive on Mar 1, 1958, and that death occurred at 1.20 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: C M Van Poole M.D.
ADDRESS (Street, city or town, state): Mt Airy, Md
DATE SIGNED: 3-1-58
PHYSICIAN'S NAME (Type): C M Van Poole

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: March 4, 1958
22c. NAME OF CEMETERY OR CREMATORY: Poplar Springs Meth.
22d. LOCATION (City, town, or county) (State): Poplar Springs, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Elmer L. Wolsonholm
ADDRESS: Damascus, Md.
24a. REC'D BY REGISTRAR DATE: MAR 5 '58
24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3429 **CERTIFICATE OF DEATH** 03414

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH
a. COUNTY: Howard — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Woodbine
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Md. b. COUNTY: Howard
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Woodbine
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Milton — Middle: Franklin — Last: Johnson

4. DATE OF DEATH: Month: March — Day: 27 — Year: 1958

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: Sept. 13, 1873

9. AGE (In years last birthday): 84 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Agriculture

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Johnson

14. MOTHER'S MAIDEN NAME: Minnie Fisher

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: Unk

17. INFORMANT: Address: Mrs Alice Delph - Woodbine, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cardiac Arrest, Congestive Failure, — INTERVAL BETWEEN ONSET AND DEATH:

4220

DUE TO (b): Edema, Arteriosclerotic heart disease, — Jan 58 to

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

DUE TO (c): Arteriosclerosis generalize, Senile degeneration — 27 March 58

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour o. m. / p. m. 19

20d. INJURY OCCURRED While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan, 1958, to 27 March, 1958, that I last saw the deceased alive on 27 March, 1958, and that death occurred at 5A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Howard E. Hall M.D. — ADDRESS (Street, city or town, state): Sykesville, Md. — DATE SIGNED: 27 March 58

PHYSICIAN'S NAME (Type): HOWARD E. HALL — Sykesville, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3-30-58

22c. NAME OF CEMETERY OR CREMATORY: Liberty Baptist

22d. LOCATION (City, town, or county) (State): Lisbon, Howard Co, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Luther H. Haight — ADDRESS: Sykesville, Md.

24a. REC'D BY REGISTRAR DATE: MAR 31 '58

24b. REGISTRAR'S SIGNATURE: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03415

3430

CERTIFICATE OF DEATH

Reg. Dist. No. 195

1. PLACE OF DEATH
a. COUNTY Howard — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Savage
c. LENGTH OF STAY IN 1b 45 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland — b. COUNTY Howard
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Savage
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First James — Middle Albert — Last Keeney

4. DATE OF DEATH: Month March — Day 11 — Year 1958

5. SEX: M — 6. COLOR OR RACE: W — 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ — 8. DATE OF BIRTH: May 24 1876 — 9. AGE (In years last birthday): 81 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk
10b. KIND OF BUSINESS OR INDUSTRY: Md State Tobacco Warehand
11. BIRTHPLACE (State or foreign country): Granite Md
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Israel Keeney
14. MOTHER'S MAIDEN NAME: Rebecca Young

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT — Address: James Keeney, Savage Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Uraemia — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs.
DUE TO (b) Cardio-Vascular Disease — 1 yr.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)
422.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan. 1, 1957 to Mar. 11th 1958, that I last saw the deceased alive on Mar. 11, 1958, and that death occurred at 11a M, from the causes and on the date stated above.
ACTUAL SIGNATURE Frank E. Shipley M.D. ADDRESS (Street, city or town, state) Savage, Md DATE SIGNED
PHYSICIAN'S NAME (Type) Frank E. Shipley, M.D. Savage, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF March 14 1958
22c. NAME OF CEMETERY OR CREMATORY Savage Cem.
22d. LOCATION (City, town, or county) (State) Savage Maryland

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS Laurel Md.
24a. REC'D BY REGISTRAR DATE MAR 18 '58
24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

Item 18 Film 226 3-24-58 ams

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3491

03416
Reg. Dist. No.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

1. PLACE OF DEATH
a. COUNTY: Howard Co. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Near Poplar Springs
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Howard
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mt.Airy R.F.D. Nr.Poplar Springs
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Larry — Middle: LeRoy — Last: Matthews

4. DATE OF DEATH: Month: March — Day: 5 — Year: 19 58

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Oct.15,1957

9. AGE (In years last birthday): yrs.
IF UNDER 1 YEAR: Months: 4 — Days: 20
IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Benjamin Smith

14. MOTHER'S MAIDEN NAME: Hezel Davis Matthews

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Hazel Davis Matthews Mt.Airy,R.F.D.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Viral pneumonitis — 492 X — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a).

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: a. m. / p. m. — Month, Day, Year: 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):

20f. (City or town) (County) (State):

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: B O Thomas M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: March 6,1958

EXAMINER'S NAME (Type): B.O.Thomas,M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: March 8
22c. NAME OF CEMETERY OR CREMATORY: Mt. Olive
22d. LOCATION (City, town, or county) (State): Woodbine Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Roy W. Barber
ADDRESS: Laytonsville, Md.

24a. REC'D BY REGISTRAR — DATE: MAR 10 '58
24b. REGISTRAR'S SIGNATURE: W. Pearce

2269344XV2

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3432 Item 9 Film 227 4-1-58 et

CERTIFICATE OF DEATH

Reg. Dist. No. 03417

1. PLACE OF DEATH
a. COUNTY: Howard — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Scaggsville
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Howard
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Simpsonville
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: Charles — Middle: Robert — Last: Myers

4. DATE OF DEATH: Month: March — Day: 22 — Year: 19 58

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 3/11/82

9. AGE (In years last birthday): 76 yrs. 7/12

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: John Myers

14. MOTHER'S MAIDEN NAME: Lydia Dorsey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 213-34-0220

17. INFORMANT: Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 3 months
420.0
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Arteriosclerosis — years
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from March 19, 19 58, to March 22, 19 58, that I last saw the deceased alive on March 19, 19 58, and that death occurred at 10:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: J W Bird M.D. — ADDRESS (Street, city or town, state): Sandy Spring Md — DATE SIGNED: 3/23/58

PHYSICIAN'S NAME (Type): J. W. Bird, M. D. — Sandy Spring, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3/26/58

22c. NAME OF CEMETERY OR CREMATORY: Locus Chapel,

22d. LOCATION (City, town, or county) (State): Simpsonville, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Robert L. Sunderland — ADDRESS: Rockville, Md.

24a. REC'D BY REGISTRAR DATE: MAR 26 '58

24b. REGISTRAR'S SIGNATURE:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3433

CERTIFICATE OF DEATH

03418 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Howard — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ellicott
c. LENGTH OF STAY IN 1b: 10 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Howard
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ellicott
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Hattie Middle FRANCES Last POWELL

4. DATE OF DEATH: Month March Day 4 Year 1958

5. SEX: F

6. COLOR OR RACE: Col

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: April 29 1900

9. AGE (In years last birthday): 57 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Louis Frazier

14. MOTHER'S MAIDEN NAME: Rachel Stanton

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Walter W. Powell Address: 1231 Division St. Balto

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Lobar pneumonia, cachexia — INTERVAL BETWEEN ONSET AND DEATH: 3 days
260X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) uncontrolled diabetes — several years
DUE TO
(c) extensive arteritis of lower extremities — 2 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 490X

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from March, 1957, to March, 1958, that I last saw the deceased alive on March 3, 1958, and that death occurred at 1:30 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Bertrand R Gau M.D. — ADDRESS (Street, city or town, state): 37 central Avenue — DATE SIGNED

PHYSICIAN'S NAME (Type): Bertrand R. Gau — Sykesville Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3-8-58

22c. NAME OF CEMETERY OR CREMATORY: Daisy

22d. LOCATION (City, town, or county) (State): Daisy Howard Co. Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Hattie A. Haight — ADDRESS: Ellicott City Md.

24a. REC'D BY REGISTRAR DATE: MAR 10 '58

24b. REGISTRAR'S SIGNATURE: W. Leech

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3434 **CERTIFICATE OF DEATH** 03419

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Howard MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. b. COUNTY Howard

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Harwood

c. LENGTH OF STAY IN 1b

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Harwood Pk.

d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION

d. STREET ADDRESS 1915 Loudon Ave.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Mary Middle S. Lost Robinson

4. DATE OF DEATH Month 3 Day 7 Year 19 58

5. SEX F

6. COLOR OR RACE W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH 1-30-1875

9. AGE (In years last birthday) 83 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Hampstead, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Charles W. Richards

14. MOTHER'S MAIDEN NAME Isadora Rupp

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Address Lester L. Robinson 1915 Loudon Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Apoplexy — INTERVAL BETWEEN ONSET AND DEATH 8 days
DUE TO
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
(b) Generalized arteriosclerosis — 5 yrs
DUE TO
(c) Arterial Hypertension — 6 mos / 10 yrs

443X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Senility

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. / p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb 27, 1958, to March 7, 1958, that I last saw the deceased alive on March 7, 1958, and that death occurred at 1:45 a.m., from the couses and on the dote stated above.

ACTUAL SIGNATURE A B Brumbaugh M.D. ADDRESS (Street, city or town, state) 5609 main ST DATE SIGNED 3/7/58

PHYSICIAN'S NAME (Type) B B Brumbaugh Harwood Md

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial

22b. DATE THEREOF 3-10-58

22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.

22d. LOCATION (City, town, or county) (State) Baltimore Md.

23. FUNERAL DIRECTOR'S SIGNATURE Howard N. Hutton ADDRESS 4107 Wilkens Ave.

24a. REC'D BY REGISTRAR DATE MAR 11 '58

24b. REGISTRAR'S SIGNATURE W. Leach

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03420

Reg. Dist. No.

3435

1. PLACE OF DEATH
a. COUNTY: Howard — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Jessups
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress): Rt.1 One Spot

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Howard
c. CITY OR TOWN (If outside corporate limits, write RURAL and give neorest town): Baltimore
d. STREET ADDRESS: Rt.1 One Spot
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First WILLIE — Middle MAE — Lost ROBINSON

4. DATE OF DEATH: Month March — Day 29 — Yeor 1958

5. SEX: Female

6. COLOR OR RACE: Colored

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: Sept.22,1932

9. AGE (In years last birthday): 25 yrs.

IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Georgia

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Hinton Sanders

14. MOTHER'S MAIDEN NAME: Eula C. High

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): —
(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.:

17. INFORMANT Address: Eula C. High Rt. 1 One Spot, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Internal Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 10 min.
812 X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): **19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ **CAUSE OF DEATH.**

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Pedestrian struck by automobile

20c. TIME OF INJURY Hour 12.01 a. m. p. m. — Month, Day, Yeor 3/29 1958

20d. INJURY OCCURRED While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Highway

20f. (City or town) Rt.1 One Spot — (County) Howard — (State) Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒ Suicide ☐, Hamicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Thomas F. Herbert M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED: 3-29-58

EXAMINER'S NAME (Type): Thomas F. Herbert M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal

22b. DATE THEREOF: 4/1/1958

22c. NAME OF CEMETERY OR CREMATORY: Bethal Ham

22d. LOCATION (City, town, or county) (State): Americus, Georgia

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Arlington S. Phillips 1808 N.Monroe St.

24a. REC'D BY REGISTRAR DATE: APR 2 '58

24b. REGISTRAR'S SIGNATURE:

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3436 **CERTIFICATE OF DEATH** 03421

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Howard MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City
c. LENGTH OF STAY IN 1b 6 mos
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Shaffer Convalescent Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Howard
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jessup
d. STREET ADDRESS Mission Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Catherine Middle Schneider Last
4. DATE OF DEATH Month March Day 20 Year 1958

5. SEX F
6. COLOR OR RACE W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH Feb 6 1867
9. AGE (In years last birthday) 91 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY Home
11. BIRTHPLACE (State or foreign country) Louisville Kentucky
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Jacob Seibert
14. MOTHER'S MAIDEN NAME Margaret Bloomet

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) —
16. SOCIAL SECURITY NO.
17. INFORMANT Address Mrs Everett Shinn Jessup, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uraemia — INTERVAL BETWEEN ONSET AND DEATH 3 Days

DUE TO (b) Cardio-Vascular Disease — 1 yr.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 422.1

DUE TO (c) —

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Senility

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan. 1, 1957 to Mar. 20 1958, that I last saw the deceased alive on Jan. 19, 1958, and that death occurred at 1 P. M., from the causes and on the date stated above.

ACTUAL SIGNATURE Frank E. Shipley M.D. ADDRESS (Street, city or town, state) Savage, Md. DATE SIGNED

PHYSICIAN'S NAME (Type) Frank E. Shipley, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF March 22 1958
22c. NAME OF CEMETERY OR CREMATORY Ivy Hill Cemetery
22d. LOCATION (City, town, or county) (State) Laurel Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS DeWitt Donaldson Laurel, Md
24a. RECD. BY REGISTRAR DATE MAR 26 '58
24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3437 CERTIFICATE OF DEATH

Reg. Dist. No. 03422

1. PLACE OF DEATH
a. COUNTY: Howard — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Henryton
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Howard
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Henryton
d. STREET ADDRESS: /
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First DRENDA Middle THOMAS Last

4. DATE OF DEATH: Month March Day 2 Year 1958

5. SEX: Female
6. COLOR OR RACE: Colored
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: March 15, 1875
9. AGE (In years last birthday): 82 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At Home
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: George Griffin
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT Address: Francees Brown, Henryton, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Myocarditis — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b): Bronchial Asthma
DUE TO (c): Hypertension Cerebral Hemorrhage

491X

Conditions, if ony, which gave rise to immediate couse (a), stating the underlying couse last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2/22/58, 19____, to 3/1/58, 19____, that I last saw the deceased alive on 2/15/58, 19____, and that death occurred at 11:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: W. L. Barksdale M.D.
ADDRESS (Street, city or town, state): 524 N. Gamble Baltimore
DATE SIGNED: 3-2-58

PHYSICIAN'S NAME (Type): L. Barksdale M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3-6-58
22c. NAME OF CEMETERY OR CREMATORY: West Liberty
22d. LOCATION (City, town, or county) (State): Alpha, Md

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: F. C. Higinbothom, Ellicott City, Md

24a. REC'D BY REGISTRAR DATE: MAR 5 '58
24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be completed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3438

CERTIFICATE OF DEATH

Reg. Dist. No. 03423

1. PLACE OF DEATH
a. COUNTY: Howard — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ellicott City Rural
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Rt. 144 Mayfield

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Howard
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Ellicott City Rural
d. STREET ADDRESS: Rt. 144 Mayfield
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JAMES Middle H. Lost TUCKER

4. DATE OF DEATH: Month March Day 20 Year 19 58

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 4-23-1875

9. AGE (In years last birthday): 82 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: Farm Owner

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Aaron Tucker

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT Address: Joseph Miller, Ellicott City, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Circulatory Collapse — INTERVAL BETWEEN ONSET AND DEATH: 30 min

422.1

DUE TO (b) Cardiac failure — 1 hr.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c) Arteriosclerotic cardiovascular disease — 20 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Thrombocytopenia

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 10-21, 19 57, to 3-20, 19 58, that I last saw the deceased alive on 3-17, 19 58, and that death occurred at 5:30 A. M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Thomas F. Herbert M.D. — ADDRESS (Street, city or town, state): 4th Church Road — DATE SIGNED

PHYSICIAN'S NAME (Type): Thomas F. Herbert, M.D. — Ellicott City, Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3-24-58

22c. NAME OF CEMETERY OR CREMATORY: Good Shepherd

22d. LOCATION (City, town, or county) (State): Ellicott City, Md

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: F.C. Higinbothom, Ellicott City, Md

24a. REC'D BY REGISTRAR DATE: MAR 26 '58

24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be [illegible] by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3439

03424
Reg. Dist. No.

Item 7, Film G227, 4/7/58 fcy

1. PLACE OF DEATH
a. COUNTY: Howard — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ellicott City rural
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Rt.40 opposite Browns Cabins

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore City 3 Va 1-4
d. STREET ADDRESS: 538 Bruce St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First STANLEY Middle CLIFTON Last WEBB

4. DATE OF DEATH: Month March Day 27, Year 1958

5. SEX: Male
6. COLOR OR RACE: Colored
7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 5-27-36
9. AGE (In years last birthday): 21 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life) even if retired): Porter
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Edmond Webb
14. MOTHER'S MAIDEN NAME: Agnes Jones

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 212-34-8128
17. INFORMANT: Agnes Jones Webb Address 538 Bruce St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Broken Neck (Due to auto accident) — INTERVAL BETWEEN ONSET AND DEATH: Instant
823x
DUE TO
(b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Auto went into ravine passenger thrown out of car
20c. TIME OF INJURY: Hour 1.40 a.m. p.m. Month, Day, Year 3-27-58 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Highway
20f. (City or town) Ellicott City (County) Howard (State) Md

21. I certify that I taak charge of the remains described above, held an Autapsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Donald E. Fisher M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 3-27-58
EXAMINER'S NAME (Type): Donald E. Fisher M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 4-1-58
22c. NAME OF CEMETERY OR CREMATORY: St Peter's Cemetery
22d. LOCATION (City, town, or county): Baltimore (State) Md

23. FUNERAL DIRECTOR'S SIGNATURE: V. Brooke Ruggold ADDRESS: 1463 N. Carey St
24a. REC'D BY REGISTRAR DATE: MAR 31 '58
24b. REGISTRAR'S SIGNATURE: [illegible]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3440

CERTIFICATE OF DEATH

Reg. Dist. No. 03425

1. PLACE OF DEATH
a. COUNTY: Howard — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glenelg
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Howard
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Glenelg
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ANNA Middle LOUISE Last ZEPP

4. DATE OF DEATH: Month March Day 2 Year 1958

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: 10-24-1871

9. AGE (In years last birthday): 86 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At Home

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Baltimore, Md

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Harry Lehman

14. MOTHER'S MAIDEN NAME: Harriett A. Ridgely

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT Address: Mrs. Ellsworth Linthicum, Glenelg, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Carcinoma of the rectum — INTERVAL BETWEEN ONSET AND DEATH: 3 years

154X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a. m. / p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I attended the deceased from 5-3-, 1947, to 3-2, 1958, that I last saw the deceased alive on 3-1-, 1958, and that death occurred at 9:30 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Charles S. Whitaker M.D., M.D. — ADDRESS (Street, city or town, state): — DATE SIGNED:

PHYSICIAN'S NAME (Type): Charles S. Whitaker, M.D. — Clarksville, Maryland — 3-3-58

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3-5-58

22c. NAME OF CEMETERY OR CREMATORY: Linthicum Chapel

22d. LOCATION (City, town, or county) (State): Clarksville, Md

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: F.C. Higinbotham, Ellicott City, Md

24a. REC'D BY REGISTRAR DATE: MAR 5 '58

24b. REGISTRAR'S SIGNATURE: W. Resch

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospitol or attending physicion.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55